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Comment

The challenge of recertification ☆

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Over the past few years there has been a lot of talk about changes to the profession. The temperature of the debate has been driven up by three terrible disasters: Bristol, Alder Hey, Shipman, and produced questions like:

How can the structure and function of the GMC be improved?

What is the role for revalidation?

Can complaints against doctors be managed differently and faster, and involve those outside the profession more?

Throughout there has been a gathering tide of opinion that, as a profession, we should be more accountable with the result that the principle of recertification has come to be one of the key proposals arising from the discussion.

First some definitions. Revalidation is the overarching concept of checking a practitioners continuing fitness to do a job, and is divided into two parts:

The first, relicencing, is the process designed to check a practitioner's capacity to remain on the medical register.

The second, recertification, is the process designed to check the capacity of a specialist to remain on the specialist register.

It is suggested that these processes will happen every five years.

There will probably be a role for the faculty in the process of relicencing, but this paper will focus on recertification. The faculty will undoubtedly be the standard setter in forensic and legal medicine.

So just what is the problem to which recertification is the answer?

At the heart of a lot of the work recently undertaken by the Shipman enquiry and the Chief Medical Officer lies an uncomfortable truth.

The decline in the quality of a doctor's work and an increase in the risk of complaints being made against him are both age related.[1,2] Broadly speaking, doctors tend not to become older and wiser, but older and less competent. Obviously it's highly undesirable that this state of affairs should remain unchecked.

It is unavoidable that things will go wrong in medicine from time to time. But it is equally clear that there is a collective moral imperative to put into effect processes that will minimize such risks.

When things go wrong in medical practice, whether a mistake due to lack of attention, or due to blatant negligence, patients feel as thought they are the victims of friendly fire: as though they have been shot in the back by their own side.

In the face of such risks, there is an inescapable professional responsibility that demands real effort in the areas of work quality evaluation, and skill maintenance.

A MORI poll commissioned by the Department of Health shows there is a strong belief within the general public that it is important, for GPs for example, to have their competences assessed every few years.[3] It does not require much imagination to work out that the same expectation would in all likelihood be applied to specialists such as ourselves.

Doctors questioned in the same study agreed, (although not as enthusiastically as the general public), that the benefits of inspecting all doctors outweigh the "negative implications".

More concerning perhaps was the fact that no less than 46% of the public thought that doctors were already assessed at least every five years, or less.

Presumably, this idea has its roots in a general sense that such assessments would be a good thing.

There is support for such procedures in other high risk industries.

Airline pilots are submitted to checks on an annual, or more frequent basis.[4]

Gas and electrical engineers are also required to have their skills and knowledge re-evaluated frequently and regularly. It is probably the case that as consumers, we are all comforted by the knowledge that regular professional

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re-evaluation virtually eliminates the risk of jumbo-jets will crashing onto us, or our kitchens exploding after a visit from the gas man.

At the same time, such trades and professions are not the same as clinical practice, so why should we sign up for recertification? As a profession we already have an enormous workload, we were already committed to go to many hours of Continuing Professional Development each year, and we are signed up to Good Medical Practice.

The truth is that this is not enough to meet the expectations of the public. Nor is it enough to prevent thousands of iatrogenic incidents across the whole range of specialities each year: and self-evidently not enough to halt an increasing level of litigation and complaints.

And although forensic medicine is hardly mainstream, it cannot be seen to be immune from these issues. In the relatively recent past, there have been of cases of forensic physicians not only making mistakes sufficient to warrant dismissal by police authorities, but also severe enough to lead to criminal conviction.

The recent Independent Police Complaints Commission near miss study that has been undertaken using metropolitan police forensic physicians[5] illustrates important themes about safe practice that must be heeded.

There is the evidence from many other specialities that doctors will fail more frequently if they have not been recertified than if they had been recertified.[2]

And with the political interest rising, progress of a kind is being forced upon the profession. The Government has come out with a number of proposals in a white paper which the GMC has summarized,[6] as being as much about sustaining, improving and assuring the standards of the majority as about identifying poor practice.

This is positive and constructive.

The white paper "Trust Assurance and Safety", itself says: "recertification will be a positive affirmation of the doctors entitlement to practise, not simply an absence of concerns".[7] It goes on to say that "Standards will be drawn up for each area of specialist recertification by the appropriate medical Royal Colleges." Clearly therefore it is proposed that the faculty will be the standard setter for forensic physicians and medicolegal advisors.

And here is the heart of the challenge.

The white paper says "evidence may be drawn from a range of sources and activities, including employer appraisal, clinical audit, simulator tests, knowledge tests, patients feedback, continuing professional development or observation of practice."

In other words, all possible means to be checked or tested may be used.

This work is to be led by the Academy of Royal Colleges, and development funding will be available from the Department of Health, so there will be an enormous amount of work for the faculty to do when these proposals are enacted.

Currently work is going on to establish the core competences, syllabuses and examinations. From this will come the bedrock of any recertification material. It may help to follow the lead of the USA, who are ahead of the UK in this arena. There it is held that the process of certification as a specialist, (which may or may not be linked in some way to membership of the faculty in our speciality), should be regarded as the first recertification.[8]

This process therefore is an effort to break with the traditional view that once doctors have got a licence to practice, it is only lost in the event of a serious professional failing. In the future, it is suggested, a licence to practice will be removed or qualified if there is a risk of a serious professional failing. From the practitioners point of view, this represents a significant change of professional culture.

But from the patients point of view, it's about effectively reducing the risk of friendly fire.

This is not about dealing with a new problem. Since time immemorial the profession has been under an obligation first and foremost to do no harm: a tacit recognition that medical practice carries risks.

As medical competence has increased, patients expectations have also increased, and the opportunities for disappointment, failure and inadequate performance have consequently all increased proportionately.

This paradoxical problem born of professional success, arguably something to celebrate, is a problem across the developed world, which is addressing the problem of fitness to practice in a number of different ways.

New Zealand has a process called the performance evaluation programme[9] which involves an audit of continuing professional development. Those that do not satisfy the audit requirements are required to undergo a colleague, self, and patient questionnaire. This process results in a report that will point out areas of excellence and areas that need improvement. There may be evidence of a need for a further competence review if there appears to be a risk to public health and safety.

In Canada, the method varies between provinces. As an example, there is a multisource feedback physician achievement programme being developed by the Royal College of Physicians and Surgeons together with the University of Calgary.[10] This process focuses on the educational programme that is required by each individual, and in the case of those that appear to be at risk, face to face support and follow up is provided. Those who turn out to be high risk practitioners undergo a detailed assessment to establish the best solution for those who are apparently the greatest risk to the public. However, the effectiveness of this approach in spotting problems and foretelling successful outcomes has yet to be determined.[11]

It is America though, with its large medical population, that provides probably the most interesting model to study.

The American Board of Internal Medicine, the largest of the 24 certifying boards in America, has been certifying internal medicine specialists since 1936. Since 1990, its certificate, which previously lasted a lifetime, was limited to 10 years. In the recertifying process, the candidate has to do two things: to undertake a review of ten cases, and to answer a two hundred multiple-choice questionnaire.

The purpose of the review of ten cases is to produce a self improvement plan. This has to be undertaken once in the lifetime of the certificate, but it's likely that this exercise will soon be required once every three years.

The assessment of this will also become more rigorous. Like the current English appraisal process (which the Americans feel is further developed in the United Kingdom than the USA), it is reflective and "soft".

There are also a series of computer based tests, which can be done at home, and are open book.

The 200 question multiple choice questionnaire repeats the testing experience of the (first) certifying process. It is an objective assessment of knowledge, and within the 200 questions are 40 that are standard markers, used to ensure that the standards do not drift over time.

This is an adventurous and bold approach. The ambition is to develop it into a process of self perpetuating self improvement. In the long term, it is proposed, the American Board role would evolve into overseeing and endorsing the evidence of self improvement, and cease to have to drive the process.

This is an exciting objective, which is supported by research that shows that while recertifiers might have a lower pass rate than younger first time certifiers, (82% as opposed to 92%) on retakes, both populations pass rate rises to the same 97%.[8] The perception of the Board is that the decline in pass rate for the recertifiers is more to do with getting out of the routine of learning and testing rather than the physiology of advancing age.

There are clear advantages to this objective assessment process.

However, the flaw in the American Board scheme is the lack of objective clinical assessment. This is a challenge that has not yet been met anywhere in the world. But if a recertifying process is to be an accurate and full assessment of competences, there's a clear need to deal with it. It may be a challenge that the Faculty is well placed to develop, unfettered as it is by any preconceived notions of what it's own processes ought to be.

Recertification of course will also need to take into account the developmental nature of competence, described by Dreyfus over forty years ago.[12] The stages are:

- Novice.
- Advanced beginner.
- Competent.
- Proficient.
- Expert.
- Master.

Each stage reflects the gradual shift from rule based working (the novice stage) to entirely context based working (expert and master).

Additionally, the need to recognise the 6 core values of Good Medical Practice, should be reflected in the structure of the recertification process.

It cannot be a simple test of knowledge and clinical skills. All the components of what makes a good modern doctor will need to be revalidated, while also taking account of the complications arising from the unusual nature of forensic and legal medicine.

In particular, the ethics and rules of engagement of our interconnection with the world of jurisprudence makes for assessment challenges that are not found anywhere else in the profession.

For example, how realistically can the views of patients in custody be compared to those in the outside population?

Does it matter if they cannot?

The medical regulation process is currently in the hands of the legislators, and it is clear that there are some bold and creative ideas in the proposed changes.

But collective pride, professionalism, and above all the sense of independence that characterizes our speciality should motivate us to be led by the compassion of our own calling, rather than be driven entirely by the expediency of politicians.

As a faculty we can show an adventurous, demanding and creative approach to the process whereby we recertify ourselves remembering that competence can become a habit.[13]

Serious thought must be given to serious questions and cautious but pioneering steps in the assessment process taken to properly evaluate our competences as practitioners in the fascinating and challenging field of forensic and legal medicine, and where friendly fire can become a thing of the past.

Conflict of interest statement

None declared.

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